

condition was described in 24 patients, with a median follow-up of 12 months.<sup>6</sup> Of this group, three patients with sella destruction and one with focal sella depression were not cured; and in two patients who initially had been considered cured reoperations were required. These data, which are consistent with those obtained at this institution, point to the difficulty of identifying and totally removing microadenomas that cause Cushing disease. Although it has been suggested that pituitary irradiation prevents the development of the Nelson syndrome, other studies have indicated that this is not true.<sup>7</sup> Lawrence and Linfoot describe the development of this syndrome in two instances after treatment of Cushing disease with proton irradiation.

How should we, as physicians, treat our patients with these conditions? At present, therapy is probably determined to a considerable extent by the facilities available in a given area. It appears that the proton beam is an adequate form of therapy, but the data presented in the study under discussion are insufficient to allow firm conclusions. The distance that a patient is required to travel with resulting expense and inconvenience will probably continue to limit the use of this form of treatment. In those patients in whom extension of the tumor into the sphenoidal area is found or who fail to be cured adequately by the transsphenoidal approach, irradiation should be considered. It is unfortunate that neither form of therapy appears adequate for patients with suprasellar extension; therefore, early diagnosis and definitive therapy before development of such extension is highly desirable. In those patients in whom microsurgical procedures are unsuccessful for pituitary-dependent Cushing disease, pituitary irradiation and bilateral adrenalectomy are adequate alternatives.<sup>8-10</sup> It is important that in centers where various forms of therapy are being used to treat these potentially fatal diseases, data concerning the efficacy of each approach be collected as well as information concerning the follow-up of patients. This information should be made available to practicing physicians.

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## Self-Care as a Cost Containment Measure

ONE OF THE MORE RECENT in a long line of assumptions about health care costs is that if people can be instructed and trained to take care of themselves, this will reduce the cost of health care. One is reminded of other assumptions that have received popular credence and public support, both conceptually and fiscally. Two examples are "If more health care is given to more people this will reduce costs because people will be healthier and not need so much care" and "If more doctors are trained and brought into practice an oversupply of physicians will cause them to reduce their fees and this will solve the problem of the rising cost of health care." These and other measures have so far had an effect quite opposite to what their advocates intended—they have added to the overall cost of care, although probably with a benefit of better care for more people.

Self-care is now being touted as a cost control measure. A randomized trial of the effect of a self-care book on the number of visits to physicians, recently reported in *The Journal of the American Medical Association*,<sup>1</sup> concluded that a large-scale distribution of this self-care book did not result in significantly less dependence on physicians for treatment of acute medical problems, even though half of the families read most or all of the book, and more than a third used it to deal with a significant medical problem.

From this study it appears that there may be a trade-off, that is, emphasis on self-care may cause some to seek help from a physician less often, while others will be newly stimulated to call upon

a physician. While self-care may not reduce health care costs significantly, it may well result in more care for more people, as indeed have some of the other unfounded assumptions about cost containment.

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## Agreement, Suggestions and Predictions Concerning Coronary Artery Bypass Operations

MILLER AND IVEY describe their indications for coronary bypass operations in their article "Selection of Patients for Coronary Artery Bypass Operations" elsewhere in this issue. The controversy regarding bypass operations has subsided, largely because the procedure relieves angina pectoris in 90 percent of patients, with complete relief occurring in 60 percent to 70 percent of them. Further, coronary bypass operations carried out by a team that has an operative risk of about 1 percent, will prolong the lives of symptomatic patients who have obstruction of the left main coronary artery, triple-vessel or double-vessel obstruction and, possibly, the lives of some patients with high-grade obstruction of the left anterior descending artery proximal to the first septal perforator and first diagonal.

Scientific evidence to support the view expressed above is adequate except for data concerning single-vessel disease (including the left anterior descending artery). As will be discussed later, we need a longer follow-up period (maybe more than five years) and a different method of classifying single-vessel disease than is currently used to study the survival of patients with this type of obstruction. In the meantime, I recommend bypass operations for these patients if there is evidence of subtotal obstruction of the left anterior descending artery, proximal to the first septal perforator and first diagonal; poor collateral flow; good contractility of the left ventricle, and evidence of ischemia (symptoms, positive findings on an exercise electrocardiographic stress test or on an exercise thallium scan).

It has become apparent that the variables a

physician must consider in determining the need for coronary bypass operations include the patient's age and symptoms, the location of the obstructing lesions, the contractile state of the left ventricle, the status of the distal coronary arteries and the presence or absence of other diseases.

#### Suggestions

Sufficient data exist to support the use of coronary bypass operations for treating patients who exhibit unstable angina pectoris, even if the angina subsides after the patient is admitted to hospital. The first-year mortality in such patients who are treated medically is almost 10 percent. In contrast, the operative risk in my own patients who have had bypass operations for unstable angina pectoris is 1 percent, and as yet there have been no deaths subsequently (follow-up period, one to four years).

The patients with unstable angina pectoris who are treated medically and who do not die within the first year may continue to have angina pectoris and myocardial infarctions. Unfortunately, their condition may eventually become inoperable because of severe damage to the left ventricle. Accordingly, procrastination because these patients are feeling better may be dangerous. It is also becoming apparent that the longer a physician procrastinates in such cases, the more likely it is that the patients will not return to work. Ideally, it is best to compress the period that includes initial examination, coronary arteriography, coronary bypass operation and the patient's return to work to three months—rather than the present six to eight months.

Accurate determination of the cost of medical care is very complex. Certain patients with angina pectoris spend considerable money on drugs, and many are admitted to hospital repeatedly for observation because of episodes of myocardial ischemia. Many patients spend less money on medication and hospital bills after the operation than they did before it. Therefore, it follows that for some patients, an inordinate delay may simply put off the time when less money need be spent for medical care.

If a bypass operation is done without inordinate delay, it may permit a patient to retain a job, thereby preventing him or her from seeking disability payments from the government or from private insurance, which is very costly. This expense, in addition to contributing less money to the Internal Revenue Service, makes procrastina-